Domesti-PUPS Medical History Form

This form is to be completed by your physician and returned together with your other application materials.

Dr. _____

Please release the requested information regarding my condition to Domesti-PUPS, Inc. This information will help determine my abilities in regard to the placement of an assistance dog.

Applicant's Name: _____

Applicant's Signature: _____

Doctor's Name: _____

Clinic Name: _____

Type of Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Patient Information:

What is the patient's primary disability? _____

What was the cause of the disability? _____

Is the disability temporary or permanent? _____

Are there significant secondary disabilities? Yes____ No____

If so, please describe: _____

At what age was he/she disabled?_____Is this disability progressive? Yes____ No____

If progressive, are there any other conditions (differences) are expected in the future? _____

_____

Is there an incapacity due to or affected by alcoholism or drug abuse? Yes____ No____

Circle all that apply:

What are the affects of the disability:

Deafness Speech Impairment Reduced Stamina Hearing Loss

Coordination Problems Limited Mobility Memory Loss Spasticity

Slowed development Vision impairment Muscular Weakness

Other: _____

Does the patient have any problems with:

Allergies Chronic Pain Heightened Emotions Depression Seizures

Skin Sensitivity Balance Brittle Bones Heat/Cold Sensitivity

Does the patient use an aid or assistive device?

Prosthesis Leg Brace Wheelchair (electric) Wheelchair (manual)

Wrist Brace Hearing Aid Crutch/Cane Walker

Other: _____

Does the patient (circle all that apply):

Drive Ride Buses Fly Driven by others Travel distances on foot/wheels

Other: _____

Current number of hours of attendant care per week:_____

ADL= Activities of Daily Living

Is this patient: Please Circle Below

A.	Able to exercise judgment and make decisions necessary for ADL?	Yes	Minimally	No
B.	Able to sustain an attention span?	Yes	Minimally	No
C.	Manifesting inappropriate behavior beyond his/her control?	Yes	Minimally	No
D.	Able to control physical and motor movement sufficient to sustain ADL?	Yes	Minimally	No
E.	Capable of perception and memory to the degree necessary to sustain ADL?	Yes	Minimally	No
F.	Able to follow directions and learn to the degree necessary to sustain ADL?	Yes	Minimally	No
G.	Under medication which impairs mental or physical functioning?	Yes	Minimally	No
H.	Capable of decisions concerning self and others needs and safety?	Yes	Minimally	No

Can you recommend this individual for an assistance dog? Yes____ No____

Is there anything that would prohibit this individual from attending and participating a 10–14 day training camp? Yes____ No____

Do you feel the assistance dog program might benefit from a consultation from you? Yes____ No____

Comments: _____

_____

_____

Physician's Signature:_____ Date: _____